TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PAIN & RECOVERY CLINIC OF NORTH HOUSTON

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-0649-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
NOVEMBER 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "PLEASE NOTE ON HCFA FORM BOX 26 PATIENT ACCOUNT MATCHES THE CLAIM NUMBER ON THE SCREENSHOT PROVIDED PER DOS; THIS CONFIRMS THE CLAIM WAS PRODUCED AND SUBMITTED ON TIME."

Amount in Dispute: $1,594.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual on 8/24/15 received the bills from PAIN & RECOVERY CLINIC NORTH..the requestor offers screen prints of its billing system as evidence of timely filing. This is insufficient to deem the bills were sent because the screen prints only state 'Sent' by 'Paper.' There is no indication the bills were sent by fax, personal deliver, or electronic transmission, which would satisfy the requirement of rule 102.4(h)(1)…Texas Mutual has no record of receiving any bill from the requestor for date 4/14/15."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 2014 through January 29, 2015	CPT Codes 97110, 97140, 97112, 97014-GP Physical Therapy Services (X3 Dates)	$1,094.40	$0.00
April 14, 2015	CPT Code 97799-CP-CA (X4 hours) Chronic Pain Management Services	$500.00	$500.00
TOTAL		$1,594.40	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.

2. 28 Texas Administrative Code §133.20, effective January 29, 2009, 34 *Texas Register* 430, sets out the procedure for healthcare providers submitting medical bills.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 Texas Administrative Code §134.600 requires preauthorization for chronic pain management services.
5. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
6. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-138-Appeal procedures not followed or time limits not met.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-29-The time limit for filing has expired.
   - 714-Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/I 95 days from DOS.
   - 731-Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.
   - 879-Rule 133.250(B)-Health care provider shall submit the request for reconsideration no later than 10 months from the date of service.
   - 891-No additional payment after reconsideration.
   - 928-HCP must submit documentation to support exception to timely filing of bill (408.0272). Notification of erroneous submission not included.
   - CAC-197-Precertification/authorization absent.
   - CAC-198-Precertification/authorization exceeded.
   - 930-Pre-authorization required, reimbursement denied.
   - 759-Service not included in and/or exceeds preauthorization approval.

Issues

1. Did the requestor support position that the disputed bills for physical therapy services rendered on November 26, 2014, January 28 and 29, 2015 were submitted timely?
2. Does a preauthorization issue exist for chronic pain management services rendered on April 14, 2015? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason codes "CAC-29" and "731."

   Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green cards to support the bill was sent to the respondent.

   The Division finds that the requestor did not submit any documentation to support that the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended for physical therapy services rendered November 26, 2014 through January 29, 2015.

2. According to the explanation of benefits, the respondent denied reimbursement for the chronic pain management services based upon reason codes "CAC-197," "CAC-198," "930," and "759."

28 Texas Administrative Code §134.600(p)(10) requires preauthorization for " chronic pain management/interdisciplinary pain rehabilitation."

On March 6, 2015, the requestor obtained preauthorization approval for 80 hours of chronic pain management services; therefore, the respondent's denial is not supported and reimbursement is due per 28 Texas Administrative Code §134.204(h).

28 Texas Administrative Code §134.204(h)(1)(A) states "(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97799-CP-CA for four (4) hours on the disputed date of service. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (5)(A) and (B), the MAR for a CARF accredited program is $125.00 per hour x four (4) hours = $500.00. The carrier paid $0.00. Therefore, the difference between the MAR and amount paid is $500.00. This amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/09/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.